SERFF Tracking Number:	*AEGX-125863788*	*State:*	*Arkansas*
Filing Company:	*Transamerica Life Insurance Company*	*State Tracking Number:*	*40616*
Company Tracking Number:	*HA AR0044307F01*		
TOI:	*H02G Group Health - Accident Only*	*Sub-TOI:*	*H02G.000 Health - Accident Only*
Product Name:	*Accidental Death*		
Project Name/Number:	*Accidental Death/HA AR0044307F01*		

Filing at a Glance

Company: Transamerica Life Insurance Company

Product Name: Accidental Death	SERFF Tr Num: AEGX-125863788	State: ArkansasLH
TOI: H02G Group Health - Accident Only	SERFF Status: Closed	State Tr Num: 40616
Sub-TOI: H02G.000 Health - Accident Only	Co Tr Num: HA AR0044307F01	State Status: Approved-Closed
Filing Type: Form	Co Status:	Reviewer(s): Rosalind Minor
	Author: SPI ADMSLH	Disposition Date: 10/24/2008
	Date Submitted: 10/17/2008	Disposition Status: Approved-Closed

Implementation Date Requested:

Implementation Date:

State Filing Description:

General Information

Project Name: Accidental Death	Status of Filing in Domicile: Pending
Project Number: HA AR0044307F01	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Small and Large
Overall Rate Impact:	Group Market Type: Other, Discretionary, Trust
Filing Status Changed: 10/24/2008	
State Status Changed: 10/24/2008	Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

The attached forms are being filed for your review and approval. These forms are new and do not replace any existing forms.

This product is a group policy that pays either a lump sum benefit upon an accidental loss (as defined in the policy) or provides an extended pay out option of the benefit. The covered person will elect how they want the benefits paid.

Additionally, there are optional rider benefits available with this plan. These optional benefits are, Accident Hospital

SERFF Tracking Number:	*AEGX-125863788*	*State:*	*Arkansas*
Filing Company:	*Transamerica Life Insurance Company*	*State Tracking Number:*	*40616*
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Indemnity Benefit Rider, Accidental Death Benefit Rider, Seat Belt Benefit Rider, Mobility Benefit Rider, Child Survivor Benefit Rider, Physician Office Visit & Wellness Benefit Rider, and an Emergency Room Visit Benefit Rider.

This product will be marketed to Financial Institutions, mortgage customers, and credit card customers on a direct mail basis.

If you should have any questions concerning this filing, please contact me.

Company and Contact

Filing Contact Information

Mary DiMarcantonio, Filing Specialist
520 Park Avenue
Baltimore, MD 21201

mdimarcantonio@aegonusa.com
(410) 209-5263 [Phone]
(410) 209-5910[FAX]

Filing Company Information

Transamerica Life Insurance Company
4333 Edgewood Road, N.E.
Cedar Rapids, IA 52499
(410) 685-5500 ext. [Phone]

CoCode: 86231
Group Code: 468
Group Name:
FEIN Number: 39-0989781

State of Domicile: Iowa
Company Type: Life and Health
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Transamerica Life Insurance Company	$50.00	10/17/2008	23265114

SERFF Tracking Number:	*AEGX-125863788*	*State:*	*Arkansas*
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	10/24/2008	10/24/2008

Amendments

Item	Schedule	Created By	Created On	Date Submitted
AR - NAIC TRANSMITTAL DOC	Supporting Document	SPI ADMSLH	10/21/2008	10/21/2008

SERFF Tracking Number:	*AEGX-125863788*	*State:*	*Arkansas*
Filing Company:	*Transamerica Life Insurance Company*	*State Tracking Number:*	*40616*
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Disposition

Disposition Date: 10/24/2008
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*AEGX-125863788*	*State:*	*Arkansas*
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Item Type	Item Name	Item Status	Public Access
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document	Explanation of Variability	Approved-Closed	Yes
Supporting Document	AR - NAIC TRANSMITTAL DOC	Approved-Closed	Yes
Supporting Document	AR - NAIC FORM FILING ATTACHMENT	Approved-Closed	Yes
Supporting Document	AR - NAIC TRANSMITTAL DOC	Approved-Closed	Yes
Form	CATASTROPHIC ACCIDENT INSURANCE POLICY	Approved-Closed	Yes
Form	GROUP CATASTROPHIC ACCIDENT INSURANCE CERTIFICATE	Approved-Closed	Yes
Form	GROUP NON-CONTRIBUTORY CATASTROPHIC ACCIDENT INSURANCE CERTIFICATE	Approved-Closed	Yes
Form	ACCIDENT HOSPITAL INDEMNITY BENEFIT RIDER	Approved-Closed	Yes
Form	ACCIDENTAL DEATH BENEFIT RIDER	Approved-Closed	Yes
Form	SEAT BELT BENEFIT RIDER	Approved-Closed	Yes
Form	MOBILITY BENEFIT RIDER	Approved-Closed	Yes
Form	CHILD SURVIVOR BENEFIT RIDER	Approved-Closed	Yes
Form	PHYSICIAN OFFICE VISIT & WELLNESS BENEFIT RIDER	Approved-Closed	Yes
Form	EMERGENCY ROOM VISIT BENEFIT RIDER	Approved-Closed	Yes
Form	ENROLLMENT FORM	Approved-Closed	Yes

SERFF Tracking Number:	*AEGX-125863788*	*State:*	*Arkansas*
Filing Company:	*Transamerica Life Insurance Company*	*State Tracking Number:*	*40616*
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Product Name:	*Accidental Death*		
Project Name/Number:	*Accidental Death/HA AR0044307F01*		

Amendment Letter

Amendment Date:

Submitted Date: 10/21/2008

Comments:

Please revise our marketing request to include inbound and outbound telemarketing and on the internet as well as direct mail.

Attached, please find a revised transmittal document with the change highlighted.

Changed Items:

Supporting Document Schedule Item Changes:

User Added -Name: AR - NAIC TRANSMITTAL DOC

Comment:

AR - NAIC TRANSMITTAL DOC.PDF

SERFF Tracking Number:	*AEGX-125863788*	*State:*	*Arkansas*
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Project Name/Number:	*Accidental Death/HA AR0044307F01*		

Form Schedule

Lead Form Number: TCA1000GP

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	TCA1000GP	Policy/Contract/Fraternal Certificate	CATASTROPHIC ACCIDENT INSURANCE POLICY	Initial		50	TCA1000GP.PDF
Approved-Closed	TCA1000GC	Certificate	GROUP CATASTROPHIC ACCIDENT INSURANCE CERTIFICATE	Initial		50	TCA1000GC.PDF
Approved-Closed	TCA2000GC	Certificate	GROUP NON-CONTRIBUTORY CATASTROPHIC ACCIDENT INSURANCE CERTIFICATE	Initial		52	TCA2000GC.PDF
Approved-Closed	TCA1001GR	Certificate Amendment, Insert Page, Endorsement or Rider	ACCIDENT HOSPITAL INDEMNITY BENEFIT RIDER	Initial		50	TCA1001GR.PDF
Approved-Closed	TCA1002GR	Certificate Amendment, Insert Page, Endorsement or Rider	ACCIDENTAL DEATH BENEFIT RIDER	Initial		50	TCA1002GR.PDF
Approved-Closed	TCA1003GR	Certificate Amendment, Insert Page, Endorseme	SEAT BELT BENEFIT RIDER	Initial		50	TCA1003GR.PDF

		nt or Rider					
Approved-Closed	TCA1004GR	Certificate Amendment, Insert Page, Endorsement or Rider	MOBILITY BENEFIT RIDER	Initial		50	TCA1004GR.PDF
Approved-Closed	TCA1005GR	Certificate Amendment, Insert Page, Endorsement or Rider	CHILD SURVIVOR BENEFIT RIDER	Initial		50	TCA1005GR.PDF
Approved-Closed	TCA1006RM	Certificate Amendment, Insert Page, Endorsement or Rider	PHYSICIAN OFFICE VISIT & WELLNESS BENEFIT RIDER	Initial		50	TCA1006RM.PDF
Approved-Closed	TCA1007RM	Certificate Amendment, Insert Page, Endorsement or Rider	EMERGENCY ROOM VISIT BENEFIT RIDER	Initial		50	TCA1007RM.PDF
Approved-Closed	TCA1100GE	Application/Enrollment Form	ENROLLMENT FORM	Initial		0	TCA1100GE.PDF

TRANSAMERICA LIFE INSURANCE COMPANY

A Stock Company – Home Office: 4333 Edgewood Road N.E., Cedar Rapids IA 52499
(referred to as we, us, our)

This Policy is issued to the Policyholder named in the Schedule. The Policy is issued in consideration of a completed application and payment of premiums as provided by its terms.

We agree to pay benefits in accordance with all the provisions of this Policy.

Premiums are payable to us or our agent in amounts determined by this Policy. The first premium is due on the Effective Date. Future premiums are due thereafter as provided by the terms of this Policy.

EFFECTIVE DATE; RENEWAL AGREEMENT

EFFECTIVE DATE. This Policy and the insurance provided by it become effective 12:01 A.M. Standard Time at the Policyholder's address on the Effective Date shown on the Schedule.

RIGHT TO RENEW. This Policy is renewable at your option or our option subject to the payment of premiums when due. The Covered Person may renew his insurance subject to the Individual Termination of Insurance provision.

The provisions found on the following attached pages form a part of this Policy as if recited over the signatures shown below.

This Policy is executed on the Effective Date, at Cedar Rapids, Iowa.

GROUP CATASTROPHIC ACCIDENT INSURANCE POLICY
NON-PARTICIPATING

LIMITED BENEFIT, PLEASE READ CAREFULLY

Craig D. Vermie — Secretary

Brenda Clancy — President

TCA1000GP

INDEX

SCHEDULE OF BENEFITS

Group Policy Number:	MZ 00-000
Effective Date:	May 1, 2008
Anniversary Date:	May 1, 2009
The Policyholder:	ABC Association

(referred to as you, your, and yours)

BENEFITS

NON-CONTRIBUTORY COVERAGE

	MEMBER
Catastrophic Accident Benefit:	[$1,000 - 10,000]

[All benefits will reduce to [50%] at age [70].]

[Coverage terminates at age [85].]

CONTRIBUTORY COVERAGE

	MEMBER	**DEPENDENT**
Catastrophic Accident Benefit	[$10,000 - $2,000,000]	[$10,000 - $2,000,000]

Catastrophic Accident Benefit

PAYMENT OPTIONS:

1.	EXTENDED PAY-OUT	
	INITIAL PAYMENT:	[$50,000-$200,000]
	MONTHLY PAYMENT FOR [1-10] YEARS	[$5,000-$20,000]
OR		
2.	LUMP SUM PAYMENT	[$10,000-$2,000,000]

[All benefits, including any additional benefit riders, will reduce to [50%] at [Covered Person's] age [70].]

Coverage terminates at Covered Person's age [85].

Inflation Benefit	[5-10%] of initial benefit amount

The inflation increases begin on the Covered Person's [second] anniversary] [effective date] and thereafter every [three] [years] [quarter] for a total of [two] increases.
Maximum Benefit Payable: up to [110% - 200%] [of the original issued benefit.]

ADDITIONAL BENEFITS	**AMOUNTS & LIMITS**	
	MEMBER	**DEPENDENT**
Accident Hospital Indemnity Benefit	[$100-$500] per day	[$100-$500] per day
[Elimination Period: [1-30] continuous days.] Maximum Benefit Period: [90-365] days.		
Seatbelt Benefit	[$10,000]	[$5,000]
Mobility Benefit	[$10,000]	[$5,000]
Accidental Death Benefit	[$25,000 - $500,000]	[$25,000 - $500,000]
Child Survivor Benefit		
For each eligible child	[$2,000]	[$1,000]
Increase of Catastrophic Accident Benefit if no eligible children:	[$2,000]	[$1,000]
Physician Office Visit Benefit	[$10-$250] per visit up to a maximum of [1-6] visits per Covered Person per [calendar year][quarter]. Only one Physician Office Visit Benefit is payable for each accident [or each Sickness.]	[$10-$250]
Wellness Benefit	[$25-$100] for one visit per Covered Person per calendar year.	[$25-$100]
Emergency Room Visit Benefit	[$10-$250] per visit up to a maximum of [1-6] visits per Covered Person per [calendar year][quarter].	[$10-$250]

Only one Emergency Room Visit Benefit is payable for each accident.

DEFINITIONS

When used in this Policy the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

COVERED PERSON means the insured Member **[**and his insured Dependent, if any. **]**

[DEPENDENT means the Member's spouse, unless they are legally separated. A spouse who is insured under this Policy as a Member will not be eligible as a Dependent.**]**

INJURY means bodily injury caused by an accident. The accident must occur while the Covered Person's insurance is in force under this Policy. The Injury must be the direct cause of Loss and must be independent of disease or bodily infirmity.

LOSS means a loss for which benefits are payable under this Policy, as described in the **Catastrophic Accident Benefit** provision, and any attached Riders.

[MEMBER means a member of a Participating Organization, association or other eligible entity who has been accepted by us and has paid the required premium. The words "he", "his", and "him" refer to the Member.**]**

[PARTICIPATING ORGANIZATION means an Organization which has signed a Participation Agreement adopting the Policyholder's plan of insurance.**]**

PHYSICIAN means a person licensed by the state in which he is resident to practice the healing arts. He must be practicing within the scope of his license for the service or treatment given. The Physician may not be the Member or a member of his immediate family.

POLICY means the contract issued to the Policyholder providing the benefits described.

POLICYHOLDER means the legal entity in whose name this Policy is issued, as shown on the Schedule of Benefits. The terms "you", "your" and "yours" mean the Policyholder.

[POLICY MONTH means the period of time starting on the first day of the month; it ends on the last day of the same month.**]**

ELIGIBILITY AND EFFECTIVE DATE OF INSURANCE

ELIGIBILITY

[All Members and Spouses between the ages of 18 thru [79] will be eligible for insurance as Covered Persons.]

EFFECTIVE DATE OF INSURANCE

Issuance of a certificate is not a waiver of any of the following conditions:

MEMBERS AND DEPENDENTS Each eligible Member and his Dependent will become insured under this Policy on the Effective Date, as shown on the Certificate Schedule.

DEFERRED EFFECTIVE DATE If a Covered Person is confined for any condition in a hospital or an institution which provides medical care and treatment on the date his insurance would otherwise become effective, he will be insured the day following formal discharge from the hospital or institution.

CHANGES IN COVERAGE

If a Member adds an eligible Dependent after issue of his certificate or if any change in the benefits provided under this Policy is requested for a Covered Person, the Effective Date of Insurance for the Covered Person will be the beginning of the Policy Month following our acceptance of the enrollment form or change request and any additional required premium.

If a new eligible Dependent is added or if the change request increases the amount of coverage or adds new benefits, the Effective Date of Insurance will be deferred if the Covered Person is confined in a hospital or an institution which provides medical care and treatment on the date the insurance would otherwise become effective. The change will be effective the day following formal discharge from the hospital or institution.

CATASTROPHIC ACCIDENT BENEFIT

When we receive due proof that a Covered Person suffers a Loss, we will pay the Catastrophic Accident Benefit shown on the Schedule. The benefit payable is subject to the following conditions:

(1) the Loss must occur as a direct result of an Injury;
(2) the Loss must occur within 90 days of the accident causing the Injury; and
(3) the Covered Person must survive for at least [180 days] from the date of Loss.

We will not pay a benefit until the [180 day] period indicated in item 3 is satisfied.

Loss means:

(1) total and permanent Loss of Use of both hands or both feet;
(2) total and permanent Loss of Use of one hand and one foot;

(3) total and permanent loss of sight of both eyes;
(4) total and permanent loss of speech; or
(5) total and permanent loss of hearing in both ears.

Loss of Use means actual severance through or above a wrist or ankle or total paralysis of a limb or limbs, which is determined by competent medical authority to be permanent, complete, and irreversible.

If more than one Loss arises out of the same accident, We will pay only one benefit. This will be the largest one.

Only one Catastrophic Accident Benefit is payable for each Covered Person.

At the Covered Person's option the Catastrophic Accident Benefit will be paid either as:

1. an Extended Pay-out option of an initial benefit payment followed by monthly payments as shown on the Schedule ; or
2. a Lump Sum payment as shown on the Schedule.

If the Extended Pay-out Option is elected and the Covered Person dies after monthly payments have been initiated, payments will continue to be made to his spouse, if living; otherwise to his estate.

INFLATION BENEFIT

Benefits of this Policy [plus any attached Riders] will automatically increase subject to the following:

1. by the [amount][percentage] shown on the Schedule;
2. the increases will occur as stated on the Schedule;
3. until the Maximum Benefit Payable shown on the Schedule has been reached.

EXCLUSIONS

We will not pay a benefit for a Loss which is caused by, results from, or contributed to by:

(1) suicide, attempted suicide or a purposeful self-inflicted wound, while sane;
(2) war or any act of war, declared or undeclared;
(3) the Covered Person's taking or using any narcotic, barbiturate or any other drug, unless taken or used as prescribed by a Physician;
(4) the Covered Person's blood alcohol level being .08 percent weight by volume or higher;
(5) the Covered Person's participation in the military service duties of any state, country or international authority;

(6) sickness, bodily infirmity or their medical or surgical treatment including diagnosis (except bacterial infections which result from an Injury or accidental ingestion of a contaminated substance) or mental disease or disorder;
(7) pregnancy, including childbirth, but not including complications thereof;
(8) travel or flight in an aircraft except to the extent stated in the Limitations section below;
(9) skydiving, parasailing, hang gliding, bungee-jumping, or any similar activity;
(10) the Covered Person's participation in the commission or attempted commission of any felony; or

(11) the Covered Person's participation in any professional sporting activity for which the Covered Person receives a salary or prize money.

LIMITATIONS:

Air travel coverage is limited to a Loss sustained during the trip, while the Covered Person is a passenger, riding in or on, boarding or getting off:

1. any civilian aircraft with a current and valid normal, transport or commuter type standard airworthiness certificate as defined by the Federal Aviation Administration or its successor or an equivalent certification from a foreign government. This aircraft must be operated by a pilot with a current and valid:

    a. medical certificate; and
    b. pilot certificate with a proper rating to pilot such aircraft.

2. Any aircraft which is not subject to a certificate of airworthiness; whose design and customary and regular purpose is for transporting passengers; and which is operated by the Armed Forces of the United States of America or the Armed Forces of any foreign government.

Coverage is not provided:

1. for corporate owned or leased aircraft;
2. if a Covered Person is the pilot, operator, member of the crew or cabin attendant of any aircraft; or
3. unless we have previously consented in writing to the use, coverage is not provided for any Loss, caused by or resulting from riding in or on, boarding or getting off:

    a. any aircraft other than those expressly stated under Limitations;
    b. any aircraft being used for, or in connection with, aerial photography;
    c. any conveyance or aircraft being used for tests or experimental purposes;
    d. any aircraft that requires a special permit or waiver from the agency that has jurisdiction over conveyance, even if granted;

e. any aircraft owned or controlled by or under lease to a Covered Person or a member of the Member's family or household;

f. any aircraft operated by the Member or one of his employees including members of an employee's family or household; or

g. any conveyance used in a race or speed test.

INDIVIDUAL TERMINATION OF INSURANCE

A Covered Person's insurance ends on the earlier of:

(1) the last day of the period covered by the last premium contribution;

(2) the first renewal date of the Certificate following the date this Policy is terminated or cancelled; or

(3) the monthly renewal date on or after the Covered Person's [85th] birthday.

[(4) For Non-Contributory coverage the monthly renewal date after the Member is no longer a member of the [Policyholder][Participating Organization].

(5) For Non-Contributory coverage [the Member's [1st] anniversary date] [[1] year(s) after the Member's effective date of coverage.]]

The Member may cancel his coverage upon notice to us. Notice is deemed given when made in writing, communicated verbally by telephone or in person, or by any other means acceptable to us. Unless requested otherwise, coverage is cancelled as of the date the cancellation request is made.

[In the event this Policy is terminated by You or by us, [we] [You] will give the Member 31 days notice of the event.]

In the event the insurance stops, it does not affect payment for a loss which began while the coverage was in force.

[In the event the Member's coverage ends because he has reached age [85] and his spouse is a Covered Person, the spouse may contact us to become the Member under the Certificate. Otherwise, the coverage will terminate on the next renewal date.]

PREMIUMS

We provide insurance coverage in return for premium payment. **[**Premiums are payable by the insured Member. The Member's first premium is due on his Effective Date.**]**

[Premiums are paid to us on or before the due date.] The initial **[**monthly**]** premium rates are shown on the Table of Premiums. [For Non-Contributory coverage all premiums shall be paid by the [Policyholder] [Participating Organization] to Our Administrative Office on or prior to the day they are due.] [All premiums shall be paid by the [Policyholder]

[Participating Organization] to Our Administrative Office on or prior to the day they are due.] [For the first [30][60][90] days of coverage, the premium will be paid by the [Policyholder][Participating Organization.] [The Member is required to contribute 100 percent of the premium payable under this Policy [after the [30][60][90] days.] [If at any time the [Policyholder][Participating Organization] refuses to accept such contributions and pay the premium for the Member, he may pay such premium directly to our Administrative Office on or prior to the day it is due.]

PREMIUM CHANGES We have the right to change the premium rates on any premium due date. We will provide written notice at least 31 days before the date of change. The premium rates may also be changed at any time the terms of this Policy are changed.

[Premiums may be paid monthly, quarterly, semi-annually, or annually. The premium mode may be changed by sending us a written request. Upon our approval, the change will be made.]

GRACE PERIOD This Policy has a 31 day grace period for the payment of each premium due after the first premium. Coverage will continue in force during the grace period. It will terminate at the end of the grace period if all premiums which are due are not paid. We will require payment of all premiums for the period this coverage continues in force including the premiums for the grace period.

[REINSTATEMENT OF INSURANCE If we terminate insurance for nonpayment of premium, the Member may reinstate coverage within 90 days following the last unpaid premium due date. He must pay all overdue premium. The reinstated policy will not cover a loss which occurred during the lapse period.]

UNPAID PREMIUM When a claim is paid for a loss incurred during the Grace Period, any premium due and unpaid may be deducted from the claim payment.

GENERAL PROVISIONS

ACTS OF THE POLICYHOLDER In administering this Policy all Covered Persons must be treated equally. We will rely on your acts.

BENEFICIARY All benefits are payable to the Member, if living. Unless he specifies otherwise, any other benefit due for loss of life will be paid as follows:

1. at his death, it will be paid to his living lawful spouse, or if he does not have one;
2. in equal shares to his living, lawful children, or if there are none;
3. in equal shares to his living lawful parents, or if there are none;
4. in equal shares to his living, lawful brothers and sisters, or if there are none;
5. to his estate.

Spouse means only the one to whom the Member is lawfully married on the date of his death. Except in the case of legal adoption, lawful children, parents, brothers, and sisters do not mean “step” children, parents, brothers, or sisters.

The Member may name any person to be his Beneficiary at the time of enrollment. The Member may change his Beneficiary at any time. When we receive and record the change request, it will take effect as of the date the Member signed it. If the Member dies prior to the date we receive and record the change, any payment we make to the new Beneficiary will be valid. The prior Beneficiary's interest ends the date the new designation takes effect.

If more than one Beneficiary is named without stating their respective interests, they will share equally. If a Beneficiary dies before the Member, that interest ends. The Beneficiaries that survive will share equally unless the Member makes a written request to the contrary.

CERTIFICATES Certificates will be provided for each Member. They will describe the coverage provided; to whom benefits are paid and the provisions of this Policy which apply to Covered Persons.

The certificate is not a part of this Policy. Any conflict between the terms of the certificate and this Policy will be decided in favor of the Policy. A copy of the Policy may be examined at your office or the office of the group insurance administrator.

If the Member is not satisfied for any reason, he may return his certificate within [30][60][90] days after receipt. His premium will be refunded. When so returned, the certificate will be void from the beginning. The certificate must be returned to us at our Home Office or to our authorized agent.

CLERICAL ERROR Clerical errors or delays in keeping records for this Policy will not deny insurance which would otherwise have been granted; not extend insurance which otherwise would have ceased and call for a fair adjustment of premium and benefits to correct the error.

CONFORMITY TO LAW Any provision of this Policy which is in conflict with the laws of the state in which it is issued is amended to conform with the laws of that state.

ENTIRE CONTRACT; CHANGES This Policy, your application, and any other attachments is the entire contract between us. Any statement you or the Member makes is a representation and not a warranty. No statement will be used by us to void or reduce benefits unless that statement is a part of the written application.

This Policy may be changed at any time by written agreement between us. Only our President, Vice-President or Secretary may change or waive the provisions of this Policy. No agent or other person may change this Policy or waive any of its terms. The change will be endorsed on this Policy.

INCONTESTABILITY After this Policy has been in force for two years, it can only be contested for non-payment of premiums. No statement made by a Covered Person can be used in a contest after his insurance has been in force two years during his lifetime. No

statement a Covered Person makes can be used in a contest unless it is in writing and signed by him.

MISSTATEMENT OF AGE If the age of a Covered Person has been misstated, all amounts payable shall be in the amount the premium paid would have bought for the correct age. If, as a result of misstatement, we accept a premium for any period when coverage would not normally have been in effect, then our liability for such period shall be a refund, upon request, of all premiums paid for such period.

NONPARTICIPATING This Policy is a nonparticipating Policy; it does not share in our surplus.

[OTHER INSURANCE IN THIS COMPANY The Covered Person may have only one Catastrophic Accident certificate or policy in force with us or any other AEGON, U.S.A. Inc. affiliate at one time. If we determine that any other such certificates or policies are in force while this one is in force, the Covered Person must choose which coverage he wants to remain active. All other insurance will be terminated. All premiums paid for canceled certificates or policies will be returned to the Member.**]**

RECORDS Sufficient records must be maintained to show the names of all Covered Persons; the dates they became insured; and any such other information required to administer this Policy.

RIGHT TO TERMINATE You or We may end this Policy by giving written notice to the other party 31 days prior to the desired termination date.

WORKER'S COMPENSATION This Policy is not a Worker's Compensation Policy. It does not satisfy any requirement for coverage by Worker's Compensation Insurance.

CLAIM PROVISIONS

NOTICE OF CLAIM We must be given written notice of claim within 20 days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice must contain the Covered Person's name and enough information to identify him. Notice may be mailed to our Administrative Office or to our agent.

CLAIM FORMS When we receive notice of claim, the claimant will be sent forms to file proof of loss. If the forms are not sent within 15 days after we receive notice, then the claimant will meet the proof of loss requirements by giving us a written statement of the nature and extent of the loss. This must be sent to us within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS Written proof must be given to us within 90 days after the date of the loss or as soon as possible thereafter. Proof must, however, be furnished no later than one year from the time it is otherwise required, except in the absence of legal capacity.

PAYMENT OF CLAIMS We will pay all benefits covered by this Policy as soon as we receive proper written Proof of Loss sufficient to determine liability.

Benefits for loss of life will be paid in accordance with the beneficiary designation in effect at the time of payment. All other benefits are paid directly to the Member, unless otherwise directed.

If a Beneficiary is a minor and there is no parent or legal guardian, or if he cannot give a valid release, the benefit will be paid as follows: to the person or institution we decide has assumed custody or support of the Beneficiary.

Any payment that we make in good faith will fully discharge us to the extent of that payment.

RIGHT OF RECOVERY If payments for claims exceed the maximum amount payable under any benefit provisions or riders of this Policy, we have the right to recover the excess of such payments.

PHYSICAL EXAMINATION AND AUTOPSY At our expense, we have the right to have the Covered Person examined as often as necessary while a claim is pending. At our expense, we may require an autopsy unless the law forbids it.

LEGAL ACTIONS No legal action may be brought to recover against this Policy within 60 days after written proof of loss has been given. No such action will be brought after three years from the time written proof of loss is required to be given.

If a time limit of this Policy is less than allowed by the laws of the state where the Covered Person lives, the limit is extended to meet the minimum time allowed by such law.

TRANSAMERICA LIFE INSURANCE COMPANY

A Stock Company – Home Office: 4333 Edgewood Road N.E., Cedar Rapids IA 52499

(referred to as we, us, our)

We certify that, subject to the terms of the Group Policy, the Member named in the Certificate schedule (referred to as you, your and yours) is insured for the benefits described in this Certificate. Your eligible Dependent, if any, for whom premiums have been paid is also insured for the benefits described in this Certificate.

EFFECTIVE DATE OF INSURANCE

The insurance takes effect at 12:01 A.M. Standard Time on the Effective Date shown on the Certificate schedule. **[**If the Covered Person is confined for any condition in a hospital or an institution which provides medical care or treatment on the date his insurance would otherwise become effective, he will be insured the day following formal discharge from the hospital or institution.**]**

In this Certificate Transamerica Life Insurance Company will be called we, our or us. This Certificate summarizes certain provisions of the Group Policy. All coverage and provisions are subject to those in the Group Policy issued to the Policyholder.

[THIRTY][SIXTY][NINETY] DAY RIGHT TO EXAMINE CERTIFICATE

If you are not satisfied for any reason, you may return your Certificate within [30][60][90] days after receipt. Your premium will be refunded. When so returned, the Certificate is void from the beginning. Return the Certificate to us at our Home Office or to our authorized agent.

Our President and Secretary witness this Certificate.

PLEASE READ YOUR CATASTROPHIC ACCIDENT INSURANCE CERTIFICATE CAREFULLY

LIMITED BENEFIT, PLEASE READ CARFEULLY

Craig D. Vermeer — Secretary

Brenda Clancy — President

TCA1000GC

INDEX

SCHEDULE OF BENEFITS

MEMBER'S NAME: [John Doe**]** **MEMBER'S AGE: [**40**]**

DEPENDENT SPOUSE: [Jane Doe**]** **DEPENDENT'S AGE: [**40**]**

EFFECTIVE DATE OF COVERAGE: [June 1, 2008**]** **GROUP POLICY: [**MZ 00-000**]**

CERTIFICATE NUMBER: [000001**]**

POLICYHOLDER: [ABC Association**]**

MONTHLY PREMIUM: [$00.00**]**

Insurance Benefits are determined by this schedule and the terms of the Group Policy.

BENEFITS

	MEMBER	DEPENDENT
Catastrophic Accident Benefit	[$10,000 - $2,000,000]	[$10,000 - $2,000,000]

Catastrophic Accident Benefit

PAYMENT OPTIONS:

1. EXTENDED PAY-OUT

INITIAL PAYMENT:	[$50,000-$200,000]
MONTHLY PAYMENT FOR [1-10] YEARS	[$5,000-$20,000]

OR

2. LUMP SUM PAYMENT [$10,000-$2,000,000]

[All benefits, including any additional benefit riders, will reduce to [50%] at [Covered Person's] age [70].]

Coverage terminates at Covered Person's age [85].

Inflation Benefit	[5-10%] of initial benefit amount	[5-10%] of initial benefit amount

The inflation increases begin on your [second] anniversary][effective date] and

thereafter every [three] [years] [quarter] for a total of [two] increases.
Maximum Benefit Payable: up to [110% - 200%] [of the original issued benefit.]

ADDITIONAL BENEFITS	**AMOUNTS & LIMITS**	
	MEMBER	**DEPENDENT**
Accident Hospital Indemnity Benefit	[$100-$500] per day	[$100-$500] per day
[Elimination Period: [1-30] continuous days.] Maximum Benefit Period: [90-365] days.		
Seatbelt Benefit	[$10,000]	[$5,000]
Mobility Benefit	[$10,000]	[$5,000]
Accidental Death Benefit	[$25,000 - $500,000]	[$25,000 - $500,000]
Child Survivor Benefit		
For each eligible child	[$2,000]	[$1,000]
Increase of Catastrophic Accident Benefit if no eligible children:	[$2,000]	[$1,000]
Physician Office Visit Benefit	[$10-$250] per visit up to a maximum of [1-6] visits per Covered Person per [calendar year][quarter]. Only one Physician Office Visit Benefit is payable for each accident [or each Sickness.]	[$10-$250]
Wellness Benefit	[$25-$100] for one visit per Covered Person per calendar year.	[$25-$100]
Emergency Room Visit Benefit	[$10-$250] per visit up to a maximum of [1-6] visits per Covered Person per [calendar year][quarter]. Only one Emergency Room Visit Benefit is payable for each accident.	[$10-$250]

DEFINITIONS

When used in this Certificate the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

COVERED PERSON means you [and your insured Dependent, if any.]

DEPENDENT means your spouse, unless you are legally separated. A spouse who is insured under the Group Policy as a Member will not be eligible as a Dependent.

GROUP POLICY means the contract issued to the Policyholder providing the benefits described.

INJURY means bodily injury caused by an accident. The accident must occur while the Covered Person's insurance is in force under the Group Policy. The Injury must be the direct cause of the Loss and must be independent of disease or bodily infirmity.

LOSS means a loss for which benefits are payable under the Group Policy, as described in the Catastrophic Accident Benefit provision, and any attached Riders.

[PARTICIPATING ORGANIZATION means an Organization which has signed a Participation Agreement adopting the Policyholder's plan of insurance.**]**

PHYSICIAN means a person licensed by the state in which he is resident to practice the healing arts. He must be practicing within the scope of his license for the service or treatment given. The Physician may not be you or a member of your immediate family.

POLICYHOLDER means the legal entity in whose name the Group Policy is issued, as shown on the Schedule of Benefits.

[POLICY MONTH means the period of time starting on the first day of the month; it ends on the last day of the same month.**]**

CHANGES IN COVERAGE

[If, after your Effective Date of Insurance, you add an eligible Dependent or request a change in benefits for a Covered Person, the Effective Date of Insurance for the new coverage will be the beginning of the Policy Month following our acceptance of the enrollment form or change request, subject to the payment of any additional required premium.]

[If a new eligible Dependent is added or if the change request increases the amount of coverage or adds new benefits, the Effective Date of Insurance will be deferred if the Covered Person is confined in a hospital or an institution which provides medical care and treatment on the date the insurance would otherwise become effective. The change will be effective the day following formal discharge from the hospital or institution.]

CATASTROPHIC ACCIDENT BENEFIT

When we receive due proof that a Covered Person suffers a Loss, we will pay the Catastrophic Accident Benefit shown on the Schedule. The benefit payable is subject to the following conditions:

(1) the Loss must occur as a direct result of an Injury;
(2) the Loss must occur within 90 days of the accident causing the Injury; and
(3) the Covered Person must survive for at least [180 days] from the date of Loss.

We will not pay a benefit until the [180 day] period indicated in item 3 is satisfied.

Loss means:

(1) total and permanent Loss of Use of both hands or both feet;
(2) total and permanent Loss of Use of one hand and one foot;
(3) total and permanent loss of sight of both eyes;
(4) total and permanent loss of speech; or
(5) total and permanent loss of hearing in both ears.

Loss of Use means actual severance through or above a wrist or ankle or total paralysis of a limb or limbs, which is determined by competent medical authority to be permanent, complete, and irreversible.

If more than one Loss arises out of the same accident, We will pay only one benefit. This will be the largest one.

Only one Catastrophic Accident Benefit is payable for each Covered Person.

At the Covered Person's option the Catastrophic Accident Benefit will be paid either as:

1. an Extended Pay-out option of an initial benefit payment followed by monthly payments as shown on the Schedule ; or
2. a Lump Sum payment as shown on the Schedule.

If the Extended Pay-out Option is elected and the Covered Person dies after monthly payments have been initiated, payments will continue to be made to his spouse, if living; otherwise to his estate.

INFLATION BENEFIT

Benefits of your Certificate [plus any attached Riders] will automatically increase subject to the following:

1. by the [amount][percentage] shown on the Schedule;
2. the increases will occur as stated on the Schedule;
3. until the Maximum Benefit Payable shown on the Schedule has been reached.

EXCLUSIONS

We will not pay a benefit for a Loss which is caused by, results from, or contributed to by:

(1) suicide, attempted suicide or a purposeful self-inflicted wound, while sane;

(2) war or any act of war, declared or undeclared;

(3) the Covered Person's taking or using any narcotic, barbiturate or any other drug, unless taken or used as prescribed by a Physician;

(4) the Covered Person's blood alcohol level being .08 percent weight by volume or higher;

(5) the Covered Person's participation in the military service duties of any state, country or international authority;

(6) sickness, bodily infirmity or their medical or surgical treatment including diagnosis (except bacterial infections which result from an Injury or accidental ingestion of a contaminated substance) or mental disease or disorder;

(7) pregnancy, including childbirth, but not including complications thereof;

(8) travel or flight in an aircraft except to the extent stated in the Limitations section below;

(9) skydiving, parasailing, hang gliding, bungee-jumping, or any similar activity;

(10) the Covered Person's participation in the commission or attempted commission of any felony; or

(11) the Covered Person's participation in any professional sporting activity for which the Covered Person receives a salary or prize money.

LIMITATIONS:

Air travel coverage is limited to a Loss sustained during the trip, while the Covered Person is a passenger, riding in or on, boarding or getting off:

1. any civilian aircraft with a current and valid normal, transport or commuter type standard airworthiness certificate as defined by the Federal Aviation Administration or its successor or an equivalent certification from a foreign government. This aircraft must be operated by a pilot with a current and valid:

a. medical certificate; and
b. pilot certificate with a proper rating to pilot such aircraft.

2. Any aircraft which is not subject to a certificate of airworthiness; whose design and customary and regular purpose is for transporting passengers; and which is operated by the Armed Forces of the United States of America or the Armed Forces of any foreign government.

Coverage is not provided:

1. for corporate owned or leased aircraft;

2. If a Covered Person is the pilot, operator, member of the crew or cabin attendant of any aircraft; or
3. unless we have previously consented in writing to the use, coverage is not provided for any Loss, caused by or resulting from riding in or on, boarding or getting off:

a. any aircraft other than those expressly stated under Limitations;
b. any aircraft being used for, or in connection with, aerial photography;
c. any conveyance or aircraft being used for tests or experimental purposes;
d. any aircraft that requires a special permit or waiver from the agency that has jurisdiction over conveyance, even if granted;
e. any aircraft owned or controlled by or under lease to a Covered Person or a member of his family or household;
f. any aircraft operated by you or one of your employees including members of an employee's family or household; or
g. any conveyance used in a race or speed test.

WHEN COVERAGE ENDS

A Covered Person's insurance automatically ends on the first of the following dates:

(1) the last day of the period covered by the last premium contribution;
(2) the first renewal date of the Certificate following the date the Policy is terminated or cancelled; or
(3) the monthly renewal date on or after the Covered Person's [85th] birthday.

You may cancel your coverage upon notice to us. Notice is deemed given when made in writing, communicated verbally by telephone or in person, or by any other means acceptable to us. Unless requested otherwise, coverage is cancelled as of the date the cancellation request is made.

[In the event the Policy is terminated by the Policyholder or by us, [we] [the Policyholder] will give you 31 days notice of the event.]

In the event the insurance stops, it does not affect payment for a loss which began while the coverage was in force.

[In the event your coverage ends because you have reached age [85] and your spouse is a Covered Person, the spouse may contact us to become the Member under the Certificate. Otherwise, the coverage will terminate on the next renewal date.]

PREMIUMS

We provide insurance coverage in return for premium payment. **[**Premiums are payable by you. Your first premium is due on your Effective Date.**]** Premiums are paid to us on or before the due date. The initial **[**monthly**]** premium rates are shown on your Certificate Schedule. [All premiums shall be paid by the [Policyholder][Participating Organization] to Our Administrative Office on or prior to the day they are due.] [For the first [30][60][90] days of coverage, the premium will be paid by the [Policyholder][Participating Organization.] [You are required to contribute 100 percent of the premium payable under the Group Policy [after the [30][60][90] days.] [If at any time the [Policyholder][Participating Organization] refuses to accept such contributions and pay the premium for you, you may pay such premium directly to our Administrative Office on or prior to the day it is due.]

PREMIUM CHANGES We have the right to change the premium rates on any premium due date. We will provide written notice at least 31 days before the date of change. The premium rates may also be changed at any time the terms of the Group Policy are changed.

[Premiums may be paid monthly, quarterly, semi-annually, or annually. The premium mode may be changed by sending us a written request. Upon our approval, the change will be made.]

GRACE PERIOD You have a 31 day grace period for the payment of each premium due after the first premium. Coverage will continue in force during the grace period. It will terminate at the end of the grace period if all premiums which are due are not paid. We will require payment of all premiums for the period this coverage continues in force including the premiums for the grace period.

[REINSTATEMENT OF INSURANCE If we terminate insurance for nonpayment of premium, you may reinstate coverage within 90 days following the last unpaid premium due date. You must pay all overdue premiums. The reinstated policy will not cover a loss which occurred during the lapse period.**]**

UNPAID PREMIUM When a claim is paid for expenses incurred during the Grace Period, any premium due and unpaid may be deducted from the claim payment.

GENERAL PROVISIONS

BENEFICIARY All benefits are payable to you, if living. Unless you specify otherwise, any other benefit due for loss of life will be paid as follows:

1. at your death, it will be paid to your living lawful spouse, or if you do not have one;
2. in equal shares to your living, lawful children, or if there are none;
3. in equal shares to your living lawful parents, or if there are none;
4. in equal shares to your living, lawful brothers and sisters, or if there are none;
5. to your estate.

Spouse means only the one to whom the Covered Person is lawfully married on the date of his death. Except in the case of legal adoption, lawful children, parents, brothers, and sisters do not mean “step” children, parents, brothers, or sisters.

You may name any person to be your Beneficiary at the time of enrollment. You may change your Beneficiary at any time. When we receive and record the change request, it will take effect as of the date you signed it. If you die prior to the date we receive and record the change, any payment we make to the new Beneficiary will be valid. The prior Beneficiary's interest ends the date the new designation takes effect.

If more than one Beneficiary is named without stating their respective interests, they will share equally. If a Beneficiary dies before you, that interest ends. The Beneficiaries that survive will share equally unless you make a written request to the contrary.

INCONTESTABILITY No statement made by you can be used in a contest after your insurance has been in force two years during your lifetime. No statement you make can be used in a contest unless it is in writing and signed by you.

MISSTATEMENT OF AGE If the age of a Covered Person has been misstated, all amounts payable shall be in the amount the premium paid would have bought for the correct age. If, as a result of misstatement, we accept a premium for any period when coverage would not normally have been in effect, then our liability for such period shall be a refund, upon request, of all premiums paid for such period.

[OTHER INSURANCE IN THIS COMPANY The Covered Person may have only one Catastrophic Accident certificate or policy in force with us or any other AEGON, U.S.A. Inc. affiliate at one time. If we determine that any other such certificates or policies are in force while this one is in force, the Covered Person must choose which coverage he wants to remain active. All other insurance will be terminated. All premiums paid for canceled certificates or policies will be returned to the Member.**]**

RIGHT TO EXAMINE The Group Policy is in the possession of the Policyholder; it will be available to be inspected by you at any time during business hours at his office.

WHEN THERE IS A CLAIM

NOTICE OF CLAIM We must be given written notice of claim within 20 days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible.

The notice must contain the Covered Person's name and enough information to identify him. Notice may be mailed to our Administrative Office or to our agent.

CLAIM FORMS When we receive notice of claim, the claimant will be sent forms to file proof of loss. If the forms are not sent within 15 days after we receive notice, then the claimant will meet the proof of loss requirements by giving us a written statement of the nature and extent of the loss. This must be sent to us within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS Written proof must be given to us within 90 days after the date of the loss or as soon as possible thereafter. Proof must, however, be furnished no later than one year from the time it is otherwise required, except in the absence of legal capacity.

PAYMENT OF CLAIMS We will pay all benefits covered by this Policy as soon as we receive proper written Proof of Loss sufficient to determine liability.

Benefits for loss of life will be paid in accordance with the beneficiary designation in effect at the time of payment. All other benefits are paid directly to you, unless otherwise directed.

If a Beneficiary is a minor and there is no parent or legal guardian, or if he cannot give a valid release, the benefit will be paid as follows: to the person or institution we decide has assumed custody or support of the Beneficiary.

Any payment that we make in good faith will fully discharge us to the extent of that payment.

RIGHT OF RECOVERY If payments for claims exceed the maximum amount payable under any benefit provisions or riders of the Group Policy, we have the right to recover the excess of such payments.

PHYSICAL EXAMINATION AND AUTOPSY At our expense, we have the right to have the Covered Person examined as often as necessary while a claim is pending. At our expense, we may require an autopsy unless the law forbids it.

LEGAL ACTIONS No legal action may be brought to recover against the Group Policy within 60 days after written proof of loss has been given. No such action will be brought after three years from the time written proof of loss is required to be given.

If a time limit of the Group Policy is less than allowed by the laws of the state where the Covered Person lives, the limit is extended to meet the minimum time allowed by such law.

CATASTROPHIC ACCIDENT CERTIFICATE OF INSURANCE

GROUP POLICY: [MZ 00-000**]** **POLICYHOLDER: [**ABC Association**]**

We certify that, subject to the terms of the Group Policy, the Member to whom this Certificate is issued (referred to as you, your and yours) is insured for the benefits described in this Certificate on and following the effective date on which he is eligible.

In this Certificate Transamerica Life Insurance Company will be called we, our or us. This Certificate summarizes certain provisions of the Group Policy. All coverage and provisions are subject to those in the Group Policy issued to the Policyholder.

SCHEDULE OF BENEFITS

Catastrophic Accident Benefit: [$10,000 - $2,000,000] [as selected by the Policyholder.]

[All benefits will reduce to [50%] at attain age [70].]

[Coverage terminates at age [85].]

DEFINITIONS

When used in this Certificate the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

INJURY means bodily injury caused by an accident. The accident must occur while your insurance is in force under the Group Policy. The Injury must be the direct cause of the Loss and must be independent of disease or bodily infirmity.

LOSS means a loss for which benefits are payable under the Group Policy, as described in the Catastrophic Accident Benefit provision.

[PARTICIPATING ORGANIZATION means an Organization which has signed a Participation Agreement adopting the Policyholder's plan of insurance.**]**

PHYSICIAN means a person licensed by the state in which he is resident to practice the healing arts. He must be practicing within the scope of his license for the service or treatment given. The Physician may not be you or a member of your immediate family.

LIMITED BENEFIT, PLEASE READ CARFEULLY

CATASTROPHIC ACCIDENT BENEFIT

When we receive due proof that you suffer a Loss, we will pay the Catastrophic Accident Benefit shown on the Schedule. The benefit payable is subject to the following conditions:

(1) the Loss must occur as a direct result of an Injury;
(2) the Loss must occur within 90 days of the accident causing the Injury; and
(3) you must survive for at least [180 days] from the date of Loss.

We will not pay a benefit until the [180 day] period indicated in item 3 is satisfied.

Loss means:

(1) total and permanent Loss of Use of both hands or both feet;
(2) total and permanent Loss of Use of one hand and one foot;
(3) total and permanent loss of sight of both eyes;
(4) total and permanent loss of speech; or
(5) total and permanent loss of hearing in both ears.

Loss of Use means actual severance through or above a wrist or ankle or total paralysis of a limb or limbs, which is determined by competent medical authority to be permanent, complete, and irreversible.

If more than one Loss arises out of the same accident, We will pay only one benefit. This will be the largest one.

Only one Catastrophic Accident Benefit is payable.

EXCLUSIONS

We will not pay a benefit for a Loss which is caused by, results from, or contributed to by:

(1) suicide, attempted suicide or a purposeful self-inflicted wound, while sane;

(2) war or any act of war, declared or undeclared;

(3) your taking or using any narcotic, barbiturate or any other drug, unless taken or used as prescribed by a Physician;

(4) your blood alcohol level being .08 percent weight by volume or higher;

(5) your participation in the military service duties of any state, country or international authority;

(6) sickness, bodily infirmity or their medical or surgical treatment including diagnosis (except bacterial infections which result from an Injury or accidental ingestion of a contaminated substance) or mental disease or disorder;

(7) pregnancy, including childbirth, but not including complications thereof;

(8) travel or flight in an aircraft except to the extent stated in the Limitations section below;

(9) skydiving, parasailing, hang gliding, bungee-jumping, or any similar activity;

(10) your participation in the commission or attempted commission of any felony; or

(11) your participation in any professional sporting activity for which you receive a salary or prize money.

LIMITATIONS:

Air travel coverage is limited to a Loss sustained during the trip, while you are a passenger, riding in or on, boarding or getting off:

1. any civilian aircraft with a current and valid normal, transport or commuter type standard airworthiness certificate as defined by the Federal Aviation Administration or its successor or an equivalent certification from a foreign government. This aircraft must be operated by a pilot with a current and valid:

   a. medical certificate; and
   b. pilot certificate with a proper rating to pilot such aircraft.

2. Any aircraft which is not subject to a certificate of airworthiness; whose design and customary and regular purpose is for transporting passengers; and which is operated by the Armed Forces of the United States of America or the Armed Forces of any foreign government.

Coverage is not provided:

1. for corporate owned or leased aircraft;
2. If you are the pilot, operator, member of the crew or cabin attendant of any aircraft; or
3. unless we have previously consented in writing to the use, coverage is not provided for any Loss, caused by or resulting from riding in or on, boarding or getting off:

a. any aircraft other than those expressly stated under Limitations;
b. any aircraft being used for, or in connection with, aerial photography;
c. any conveyance or aircraft being used for tests or experimental purposes;
d. any aircraft that requires a special permit or waiver from the agency that has jurisdiction over conveyance, even if granted;
e. any aircraft owned or controlled by or under lease to you or a member of your family or household;
f. any aircraft operated by you or one of your employees including members of an employee's family or household; or
g. any conveyance used in a race or speed test.

WHEN COVERAGE ENDS

Your insurance automatically ends on the first of the following dates:

(1) the last day of the period covered by the last premium contribution;
(2) the first renewal date of the Certificate following the date the Policy is terminated or cancelled;
(3) the monthly renewal date on or after your [85th] birthday; or
(4) the monthly renewal date after you are no longer a member of the [Policyholder][Participating Organization];
[(5) [your [1st] anniversary date] [[1] year(s) after your effective date of coverage].]

In the event the insurance stops, it does not affect payment for a loss which began while the coverage was in force.

GENERAL PROVISIONS

BENEFICIARY All benefits are payable to you, if living. If not living, unless you specify otherwise, benefits will be paid as follows:

1. at your death, it will be paid to your living lawful spouse, or if you do not have one;
2. in equal shares to your living, lawful children, or if there are none;
3. in equal shares to your living lawful parents, or if there are none;
4. in equal shares to your living, lawful brothers and sisters, or if there are none;
5. to your estate.

Spouse means only the one to whom you are lawfully married on the date of your death. Except in the case of legal adoption, lawful children, parents, brothers, and sisters do not mean "step" children, parents, brothers, or sisters.

RIGHT TO EXAMINE The Group Policy is in the possession of the Policyholder; it will be available to be inspected by you at any time during business hours at his office.

WHEN THERE IS A CLAIM

PAYMENT OF CLAIMS We will pay all benefits covered by this Policy as soon as we receive proper written Proof of Loss sufficient to determine liability. All benefits are paid directly to you, unless otherwise directed.

PHYSICAL EXAMINATION AND AUTOPSY At our expense, we have the right to have you examined as often as necessary while a claim is pending. At our expense, we may require an autopsy unless the law forbids it.

PROOF OF LOSS Written proof must be given to us within 90 days after the date of the loss or as soon as possible thereafter. Proof must, however, be furnished no later than one year from the time it is otherwise required, except in the absence of legal capacity.

LEGAL ACTIONS No legal action may be brought to recover against the Group Policy within 60 days after written proof of loss has been given. No such action will be brought after three years from the time written proof of loss is required to be given.

If a time limit of the Group Policy is less than allowed by the laws of the state where you live, the limit is extended to meet the minimum time allowed by such law.

TRANSAMERICA LIFE INSURANCE COMPANY
CEDAR RAPIDS, IOWA

Craig D. Vermie — Secretary

Brenda Clancy — President

ACCIDENT HOSPITAL INDEMNITY BENEFIT RIDER

This Accident Hospital Indemnity Benefit Rider is a part of the [Policy] [Certificate] to which it is attached. It is issued in consideration of the application and the continued payment of the required premium.

Upon receipt of due proof that a Covered Person is Confined as a result of the Necessary Treatment of an Injury which occurs while insurance is in force, we will pay the benefit shown on the Schedule. The benefit payable is subject to the following conditions:

(1) the Confinement must begin within 90 days of the accident causing the Injury and while insurance is in force for the Covered Person; and
(2) **[**the Covered Person must satisfy the Elimination Period specified on the Schedule.**]**

Benefits begin on the first day of Confinement **[** which follows the end of the Elimination Period.**]**

The Covered Person will receive benefits as long as he is Confined up to the Maximum Benefit Period specified in the Schedule for each period of Confinement.

Successive periods of Confinement will be considered as separate periods of Confinement; unless:

(1) the new period of Confinement is due to the same cause or causes as the prior one; and
(2) the new period of Confinement starts less than 90 days after the prior one stopped.

CONFINED OR CONFINEMENT means that the Covered Person is a registered bed patient in a Hospital and is charged room and board by the Hospital. He must be in the Hospital on the advice of a Physician and under the regular care and treatment of a Physician.

[Confinement does not include treatment received in the outpatient department of the Hospital. Outpatient treatment means service rendered for a period of less than 24 hours.]

ELIMINATION PERIOD means a period of consecutive days of Confinement for which no benefit is payable. The Elimination Period is shown on the Schedule and begins on the first day of Confinement.

HOSPITAL means an institution which meets all of the following requirements:

(1) it must be operated according to law;
(2) it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an in-patient basis for which a charge is made;
(3) it must provide diagnostic and surgical facilities supervised by Physicians;
(4) registered nurses must be on 24 hour call or duty; and
(5) the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

A Hospital is not a rest, convalescent, extended care, rehabilitation or other nursing facility, nor does it include any ward, wing or other section of the Hospital that is used for such purposes. It is not a place which primarily treats mental illness, alcoholism or drug addiction; nor does it include any ward, wing or other section of the Hospital that is used for such purposes. It is not a facility where, in the absence of insurance, there is no legal obligation to pay.

NECESSARY TREATMENT means medical treatment which is consistent with currently accepted medical practice. Any Confinement, operation, treatment, or service not a valid course of treatment recognized by an established medical society in the United States is not considered Necessary Treatment. No treatment or service or expense in connection therewith, which is experimental in nature, is considered Necessary Treatment.

We may use Peer Review Organizations or other professional medical opinions to determine if health care services are:

1. medically necessary; and
2. consistent with professionally recognized standards of care with respect to quality, frequency, and duration; and
3. provided in the most economical and medically appropriate site for treatment.

If services do not meet these criteria, expenses related to those services will not be deemed Necessary Treatment.

ADDITIONAL EXCLUSIONS

The following exclusions are in addition to any exclusions found in the [Policy][Certificate]. We will not pay a benefit under this Rider for an Injury which is caused by, results from, or contributed to by:

1. any active participation in a riot;
2. the Covered Person committing or attempting to commit an assault or being engaged in an illegal activity;
3. voluntary gas inhalation or poison voluntarily taken, administered or inhaled; or
4. taking alcohol in combination with any drug, medication, or sedative.

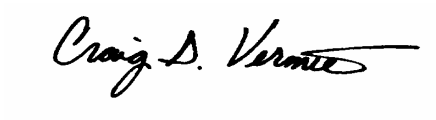
This benefit will be paid in addition to any other benefits payable under the Policy.

This Rider is subject to all of the Policy provisions, definitions, conditions, exclusions, limitations, exceptions, and reductions not in conflict herewith.

[This Rider takes effect and ends concurrently with the [Policy] [Certificate] to which it is attached.**]**

LIMITED BENEFIT, PLEASE READ CAREFULLY

TRANSAMERICA LIFE INSURANCE COMPANY



Secretary

President

ACCIDENTAL DEATH BENEFIT RIDER

This Accidental Death Benefit Rider is a part of the [Policy] [Certificate] to which it is attached. It is issued in consideration of the application and the continued payment of any premium.

Upon receipt of due proof of the death of a Covered Person, We will pay the Accidental Death Benefit shown on the Schedule to his named Beneficiary; provided:

1. death occurs as a direct result of an Injury which occurs while insurance is in force for the Covered Person; and
2. death occurs within 90 days of the accident causing the Injury and while insurance is in force for the Covered Person.

EXPOSURE AND DISAPPEARANCE

If by reason of an accident covered by the Group Policy a Covered Person is unavoidably exposed to the elements and, as a result of such exposure, suffers a covered loss and a benefit is otherwise payable, the loss will be covered by the Group Policy.

If a Covered Person is involved in an accident which results in the sinking or wrecking of a licensed public conveyance in which he was a passenger and his body is not located within one year of such accident, it will be presumed that the Covered Person died as a result of an Injury.

This benefit will be paid in addition to any other benefits payable under the Policy.

This Rider is subject to all of the Policy provisions, definitions, conditions, exclusions, limitations, exceptions, and reductions not in conflict herewith.

This Rider takes effect and ends concurrently with the [Policy] [Certificate] to which it is attached.

LIMITED BENEFIT, PLEASE READ CAREFULLY

TRANSAMERICA LIFE INSURANCE COMPANY

Craig D. Vermie — Secretary

Brenda Clancy — President

TCA1002GR

SEAT BELT BENEFIT RIDER

This Seat Belt Benefit Rider is a part of the [Policy] [Certificate] to which it is attached. It is issued in consideration of the application and the continued payment of the required premium.

Upon receipt of due proof that a Covered Person suffers a Loss and is paid a Catastrophic Accident Benefit and the Injury causing the Loss directly resulted from an automobile accident, We will pay the Seat Belt Benefit shown on the Schedule, provided:

(1) the Covered Person was operating or riding as a passenger in any Private Passenger Automobile designed for use primarily on public roads; and
(2) the Covered Person was wearing an original, equipped, factory installed or manufacturer authorized and unaltered seat belt or lap and shoulder restraint at the time of the Injury.

Verification of the Covered Person's actual use of the seat belt or lap and shoulder restraints is required as follows:

(1) through the official law enforcement report of the accident;
(2) through certification by the investigation officers; or
(3) by other reasonable proof acceptable to us.

PRIVATE PASSENGER AUTOMOBILE means a four-wheeled automobile which is required to be registered with the state for use on public highways; which is not registered to carry passengers for hire and which is of the pleasure type, including a station wagon, van, jeep or truck type with a factory rating load capacity of 2,000 pounds or less or self-propelled motor home type vehicles.

Farm equipment, forklifts, construction equipment, recreational vehicles, motorcycles, and motor scooters are specifically excluded under Private Passenger Automobile.

This benefit will be paid in addition to any other benefits payable under the Policy.

This Rider is subject to all of the Policy provisions, definitions, conditions, exclusions, limitations, exceptions, and reductions not in conflict herewith.

[This Rider takes effect and ends concurrently with the [Policy] [Certificate] to which it is attached.**]**

LIMITED BENEFIT, PLEASE READ CAREFULLY

TRANSAMERICA LIFE INSURANCE COMPANY

Secretary President

MOBILITY BENEFIT RIDER

This Mobility Benefit Rider is a part of the [Policy] [Certificate] to which it is attached. It is issued in consideration of the application and the continued payment of the required premium.

Upon receipt of due proof that a Covered Person suffers a Loss and is paid a Catastrophic Accident Benefit, We will pay the Mobility Benefit shown on the Schedule, provided:

(1) the Covered Person is required to use a wheelchair to be ambulatory on a permanent basis; and
(2) the Injury that caused the Loss is the same Injury that requires the Covered Person to need the wheelchair.

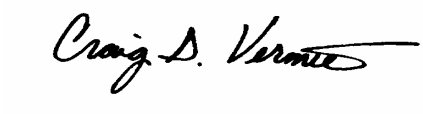
This benefit will be paid in addition to any other benefits payable under the Policy.

This Rider is subject to all of the Policy provisions, definitions, conditions, exclusions, limitations, exceptions, and reductions not in conflict herewith.

[This Rider takes effect and ends concurrently with the [Policy] [Certificate] to which it is attached. **]**

LIMITED BENEFIT, PLEASE READ CAREFULLY

TRANSAMERICA LIFE INSURANCE COMPANY



Secretary

President

CHILD SURVIVOR BENEFIT RIDER

This Child Survivor Benefit Rider is a part of the [Policy] [Certificate] to which it is attached. It is issued in consideration of the application and the continued payment of the required premium.

Upon receipt of due proof that a Covered Person suffers a Loss and is paid a Catastrophic Accident Benefit, We will pay the Child Survivor Benefit shown on the Schedule for each Eligible Dependent Child, as defined below.

Eligible Child means:

(1) each of the Covered Person's children (including step-children born to or legally adopted or children in the Covered Person's custody pursuant to an interim court order of adoption or placement of adoption, regardless of whether a final order granting adoption is ultimately issued) 18 years of age or younger, unmarried and dependent upon the Covered Person for support and maintenance; and

(2) the Covered Person's unmarried child 19 years of age but less than 25 years of age if the child is:
   a. a full-time student; and
   b. dependent upon him for support and maintenance.

Dependence for support and maintenance means that the Eligible Child must rely on the Covered Person for more than 50% of his support and be a dependent of the Covered Person for Federal Income Tax purposes.

If there are no Eligible Children, we will increase the Catastrophic Accident Benefit by the amount shown on the Schedule.

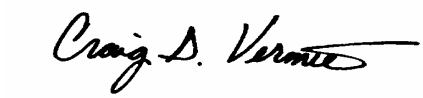
This benefit will be paid in addition to any other benefits payable under the Policy.

This Rider is subject to all of the Policy provisions, definitions, conditions, exclusions, limitations, exceptions, and reductions not in conflict herewith.

[This Rider takes effect and ends concurrently with the [Policy] [Certificate] to which it is attached. **]**

LIMITED BENEFIT, PLEASE READ CAREFULLY

TRANSAMERICA LIFE INSURANCE COMPANY



Secretary

President

TCA1005GR

PHYSICIAN OFFICE VISIT [& WELLNESS BENEFIT] RIDER

This Physician Office Visit [& Wellness Benefit] Rider is a part of the [Policy] [Certificate] to which it is attached. It is issued in consideration of the application and the continued payment of the required premium.

[Upon receipt of due proof that a Covered Person was treated by a Physician in a Physician's office for Wellness, we will pay the Wellness Benefit as shown on the Schedule. Only one Wellness benefit is payable per calendar year.]

Upon receipt of due proof that a Covered Person was treated by a Physician in a Physician's office for the Necessary Treatment of Injury, [or Sickness] we will pay the Physician Office Visit Benefit as shown on the Schedule. [Treatment of Injury must occur within [30 – 90] days of the accident causing the Injury.] Only one Physician Office Visit Benefit is payable for each accident [or Sickness]. The maximum number of visits is stated on the Schedule.

Physician Office Visit includes visits to private practices and freestanding clinics – including surgicenters, public health clinics, family planning clinics, mental health centers and faculty practice plans. It does not include visits to hospital emergency or outpatient departments; freestanding ambulatory surgery centers; Department of Veterans Affairs medical offices; or industrial, occupational, or institutional clinics.

For the purposes of this Rider, the following definitions apply:

NECESSARY TREATMENT means medical treatment which is consistent with currently accepted medical practice. Any confinement, operation, treatment, or service not a valid course of treatment recognized by an established medical society in the United States is not considered Necessary Treatment. No treatment or service or expense in connection therewith, which is experimental in nature, is considered Necessary Treatment.

We may use Peer Review Organizations or other professional medical opinions to determine if health care services are:

1. medically necessary; and
2. consistent with professionally recognized standards of care with respect to quality, frequency, and duration; and
3. provided in the most economical and medically appropriate site for treatment.

If services do not meet these criteria, expenses related to those services will not be deemed Necessary Treatment. The fact that a Physician may prescribe, authorize, or direct a service does not of itself make it medically necessary or covered by the Group Policy.

[SICKNESS means an illness or disease which first manifests while insurance for the [Covered Person] is in effect under the Policy.**]**

[WELLNESS means an office visit for routine examinations or other preventative testing.**]**

Benefits for this Rider will be paid in addition to any other benefits payable under the Policy.

This Rider is subject to all of the Policy provisions, definitions, conditions, exclusions, limitations, exceptions, and reductions not in conflict herewith.

[This Rider takes effect and ends concurrently with the [Policy] [Certificate] to which it is attached.]

LIMITED BENEFIT, PLEASE READ CAREFULLY

TRANSAMERICA LIFE INSURANCE COMPANY

Secretary President

EMERGENCY ROOM VISIT BENEFIT RIDER

This Emergency Room Visit Benefit Rider is a part of the [Policy] [Certificate] to which it is attached. It is issued in consideration of the application and the continued payment of the required premium.

Upon receipt of due proof that a Covered Person visited a Hospital Emergency Room for Necessary Treatment of an Injury, we will pay the Emergency Room Visit Benefit shown on the Schedule. Treatment must be for necessary emergency treatment of an Injury and treatment must occur within 72 hours of the accident causing the Injury.

Only one Emergency Room Visit Benefit is payable for each accident. The maximum number of visits is stated on the Schedule.

EMERGENCY ROOM means a facility licensed, if a license is required, to provide emergency care and staffed by a Physician. The facility must be a Hospital Emergency Room.

HOSPITAL means an institution which meets all of the following requirements:

(1) it must be operated according to law;
(2) it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an in-patient basis for which a charge is made;
(3) it must provide diagnostic and surgical facilities supervised by Physicians;
(4) registered nurses must be on 24 hour call or duty; and
(5) the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

A Hospital is not a rest, convalescent, extended care, rehabilitation or other nursing facility, nor does it include any ward, wing or other section of the Hospital that is used for such purposes. It is not a place which primarily treats mental illness, alcoholism or drug addiction; nor does it include any ward, wing or other section of the Hospital that is used for such purposes. It is not a facility where, in the absence of insurance, there is no legal obligation to pay.

NECESSARY TREATMENT means medical treatment which is consistent with currently accepted medical practice. Any confinement, operation, treatment, or service not a valid course of treatment recognized by an established medical society in the United States is not considered Necessary Treatment. No treatment or service or expense in connection therewith, which is experimental in nature, is considered Necessary Treatment.

We may use Peer Review Organizations or other professional medical opinions to determine if health care services are:

1. medically necessary; and
2. consistent with professionally recognized standards of care with respect to quality, frequency, and duration; and
3. provided in the most economical and medically appropriate site for treatment.

If services do not meet these criteria, expenses related to those services will not be deemed Necessary Treatment.

ADDITIONAL EXCLUSIONS

The following exclusions are in addition to any exclusions found in the [Policy][Certificate]. We will not pay a benefit under this Rider for an Injury which is caused by, results from, or contributed to by:

1. any active participation in a riot;
2. the Covered Person committing or attempting to commit an assault or being engaged in an illegal activity;
3. voluntary gas inhalation or poison voluntarily taken, administered or inhaled; or
4. taking alcohol in combination with any drug, medication, or sedative.

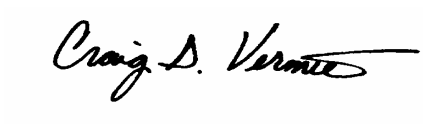
This benefit will be paid in addition to any other benefits payable under the Policy.

This Rider is subject to all of the Policy provisions, definitions, conditions, exclusions, limitations, exceptions, and reductions not in conflict herewith.

[This Rider takes effect and ends concurrently with the [Policy] [Certificate] to which it is attached.]

LIMITED BENEFIT, PLEASE READ CAREFULLY

TRANSAMERICA LIFE INSURANCE COMPANY



Secretary

President

[Catastrophic Accident] Insurance [Variable Logo]

Enrollment Form

[ABC Bank] Underwritten by Transamerica Life Insurance Company, [Admin. Office:] [Baltimore, Maryland] [Home Office: Cedar Rapids, Iowa]

[John Doe] [Please respond by][Please reply before]: [Month XX, 2001]]
[[Jane Doe]
[123 Main Street]
[Apartment #X]
[Columbia, SC XXXXX]
[Jane Doe (if covered)]

[Bar Code for Scanning Purposes] [123-103B] [5060002091717] [MZ2000104/0000F & 0001F]

Check here to [activate][select] your coverage

[Insurance provided by [ABC Bank] at NO COST TO YOU [for [60 days]]]

[• ACTIVATE UP TO [$5,000] OF INSURANCE PROVIDED BY [ABC BANK] at NO COST TO YOU. (If you have a joint account, circle the name of the person to be insured. Limit: one [NO-COST-TO-YOU] [$5,000] Certificate per joint account.)]

If you have a joint account, circle the name of the person to be insured. If you do not circle a name, the primary Account Holder will receive the no-cost-to-you certificate. Limit one certificate per activation and one per joint account.

[Please INCREASE my] [SELECT] ADDITIONAL [INSURANCE] COVERAGE [BY]: [(Check one)]

[• $1,000,000] [• $500,000] [• $300,000] [• $200,000] [• $100,000]

[NOTE: AFTER [TWO MONTHS] NO COST PERIOD, COVERAGE CONTINUES AT THE RATES SHOWN.]

[Select Your Coverage]

	Monthly Premium
[Single Coverage]	[Joint Coverage]
[• Customer Only]	[• Customer & Spouse]
$[7.95]	$[9.95]

Applicant	Date of Birth _____/_____/_____	Sex: Female_____ Male_____
Spouse	Date of Birth _____/_____/_____	Sex: Female_____ Male_____

[*Spouse coverage is [50%] of Applicant's selected benefit [(depending on plan selection)]]

[Complete and sign][Please complete:]

_ M[ale] _ F[emale] [Member's] [Insured's] [Date of Birth} [Birth Date] ____/____/____
[Home Phone ( ) _____-_____] (Required) Mo. Day Yr.
[Email address _____]
[Member's] [Name of] Beneficiary _____ Relationship to [Insured][You] _____

[_ Male _ Female [Spouse][Co-Insured's] Birth Date ____/____/____ [Home Phone ( ) _____-_____]
(Required) Mo. Day Yr.

[If you currently have another Catastrophic Accident Insurance policy or certificate in effect and do not intend to replace the current coverage, please indicate the insurance carrier: _____.] [The Covered Person may have only one Catastrophic Accident certificate or policy in force with us or any other AEGON, U.S.A. Inc. affiliate at one time.]

[SIGN, DATE AND MAIL] I [(and, if indicated below, my [spouse][co-insured])] hereby [enroll in][apply for] the Catastrophic Accident [Insurance] [Plan] underwritten by Transamerica Life Insurance Company. [By signing below, I authorize [ABC Bank] to provide Transamerica Life Insurance Company with my [ABC Bank] checking account number and any other information required to activate my coverage.] I authorize my premium to be [deducted] [processed][billed] [quarterly] monthly] and [electronically] remitted to Transamerica Life Insurance Company [from] [through] my [ABC Bank][credit card][checking][savings][share][share draft] [Credit Union] account.] [I authorize my lending institution to collect the premium with my monthly mortgage payment [after my first [2 months] of no-cost coverage]. [This authority is to remain in effect until I cancel it by written notification to the Company at least 30 days in advance of the intended termination date of my coverage.] Coverage begins on the Effective Date stated on the Certificate of Insurance [provided the first premium is paid]. [Note: Coverage amounts begin to decrease at age [70].] [If I sign and return this form without selecting a [coverage][amount][type] [I understand that if I do not select a coverage][amount] [I understand] that I will be automatically enrolled [in] [for] [Individual] [Customer and Spouse] coverage. [*A [$0.50] administrative fee will be added for each automatic account billing.] I acknowledge that I have received, read and understand the insurance disclosures [on the reverse side of this form][and][below].

ME, NH & UT RESIDENTS: THE CERTIFICATE PROVIDES LIMITED BENEFITS. REVIEW YOUR CERTIFICATE CAREFULLY.

[Insured][Customer] _____ Date _____/_____/_____
Signature of [Insured][Customer] (Required) Mo. Day Yr.

[Lance Hemmer XXXXXXX]
Licensed Resident Agent

[DO NOT SEND MONEY. COMPLETE, SIGN AND MAIL THIS FORM IN THE [POSTAGE-PAID] ENVELOPE PROVIDED.]

[ACCEPTANCE IS GUARANTEED]

[SATISFACTION GUARANTEED
You may review your Certificate of Insurance for 30 days and, if not completely satisfied, return it and receive a full refund of premiums you paid for additional insurance coverage.]

Underwriter: Transamerica Life Insurance Company [is currently rated ["A+" (Superior)] for financial strength and operating performance by the A.M. Best Company] [and] [["AA+" (Very Strong)] for claims paying ability by Standard & Poor's Insurance Rating Services.] [The A.M. Best rating is the [second highest] out of [13] given] [and] [the Standard and Poor's rating is [second highest] out of [17] given.] [Both][The] rating[s] [were][was] given in [2000].

INSURANCE DISCLOSURES

[This insurance product is not a deposit; not FDIC insured; not insured by any federal government agency; and is not guaranteed by the financial institution/affiliate.]

[The insurance product is: not FDIC or other government agency insured; not a deposit in, obligation of, guaranteed or underwritten by any bank or bank affiliate; not a condition of any banking service.]

[FDIC for all states except GA:
Insurance is not insured by the FDIC, any other agency of the United States, the bank or its affiliates; is not a deposit or other obligation of the bank or its affiliates; and is not issued, guaranteed, or underwritten by the bank, its affiliates or the FDIC.

FDIC statement for GA:
Insurance is not insured by the FDIC, any other agency of the United States, or the bank or its affiliates; is not a deposit or other obligation of the bank or its affiliates; is not guaranteed or underwritten by the bank or affiliates; and is not a condition to the provision or term of any banking service or activity.]

Certain state insurance departments require that we advise you of the following statements: [AR, CO, DC, KY, LA, ME, NM OH, OK and TN] Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a crime and may be subject to fines or confinement in prison.

[FL residents: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.]

[NJ residents: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.]

[PA residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.]

[Plan Administrator]
[P. O. Box 1000]
[Any City, State Zip Code]

SERFF Tracking Number:	*AEGX-125863788*	*State:*	*Arkansas*
Filing Company:	*Transamerica Life Insurance Company*	*State Tracking Number:*	*40616*
Company Tracking Number:	*HA AR0044307F01*		
TOI:	*H02G Group Health - Accident Only*	*Sub-TOI:*	*H02G.000 Health - Accident Only*
Product Name:	*Accidental Death*		
Project Name/Number:	*Accidental Death/HA AR0044307F01*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*AEGX-125863788*	*State:*	*Arkansas*
Filing Company:	*Transamerica Life Insurance Company*	*State Tracking Number:*	*40616*
Company Tracking Number:	*HA AR0044307F01*		
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Product Name:	*Accidental Death*		
Project Name/Number:	*Accidental Death/HA AR0044307F01*		

Supporting Document Schedules

Satisfied -Name: Application
Review Status: Approved-Closed 10/24/2008
Comments:
Form attached under the Forms Tab.

Satisfied -Name: Certification/Notice
Review Status: Approved-Closed 10/24/2008
Comments:
Attachment:
AR - READABILITY CERTIFICATION.PDF

Satisfied -Name: Explanation of Variability
Review Status: Approved-Closed 10/24/2008
Comments:
Attachment:
Explanation of Variability.PDF

Satisfied -Name: AR - NAIC TRANSMITTAL DOC
Review Status: Approved-Closed 10/24/2008
Comments:
Attachment:
AR - NAIC TRANSMITTAL DOC.PDF

Satisfied -Name: AR - NAIC FORM FILING ATTACHMENT
Review Status: Approved-Closed 10/24/2008
Comments:
Attachment:
AR - NAIC FORM FILING ATTACHMENT.PDF

Satisfied -Name: AR - NAIC TRANSMITTAL DOC
Review Status: Approved-Closed 10/24/2008

SERFF Tracking Number:	*AEGX-125863788*	*State:*	*Arkansas*
Filing Company:	*Transamerica Life Insurance Company*	*State Tracking Number:*	*40616*
Company Tracking Number:	*HA AR0044307F01*		
TOI:	*H02G Group Health - Accident Only*	*Sub-TOI:*	*H02G.000 Health - Accident Only*
Product Name:	*Accidental Death*		
Project Name/Number:	*Accidental Death/HA AR0044307F01*		

Comments:

Attachment:

AR - NAIC TRANSMITTAL DOC.PDF

STATE OF ARKANSAS

READABILITY CERTIFICATION

COMPANY NAME: **Transamerica Life Insurance Company**

This is to certify that the form(s) referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form Number	Score
TCA1000GP	50
TCA1000GC	50.5
TCA2000GC	52
TCA1001GR	50
TCA1002GR	50
TCA1003GR	50
TCA1004GR	50
TCA1005GR	50
TCA1006RM	50
TCA1007RM	50
TCA1100GE	40

Signed: 

Name: Edward G. Weigand

Title: Director

Date: 10-17-08

EXPLANATION OF VARIABLES
GROUP CATASTROPIC ACCIDENT INSURANCE POLICY AND CERTIFICATE
Forms TCA1000GP, TCA1000GC, and TCA2000GC

Certificate – Face Page

1) Deferred effective date may be included or excluded.
2) Right to Examine Certificate could be 30, 60, or 90 days.

Policy and Certificate – Schedules

1) The Policyholder, the Group Policy Number, Effective Date, and Anniversary Date will change on a case by case basis.
2) The covered persons information will vary by person.
3) Benefits and amounts will vary.

Policy and Certificate – Definitions

1) Covered Person may not include Dependent.
2) The definitions of Participating Organization and Policy Month may be included or excluded.

Policy – Eligibility and Effective Date of Insurance

1) The age could be lower or higher.
2) Dependents may or may not be covered.
3) Deferred effective date may or may not be included.

Policy and Certificate - Changes in Coverage

1) Dependent may or may not be covered.
2) Deferred effective date may or may not be included.

Policy and Certificate – Inflation Benefit

1) Inflation Benefit may or may not be included.

Policy and Certificate – When Coverage Ends

1) Termination age could be higher or lower.
2) Last paragraph may or may not be included depending on whether or not dependent coverage is included. Termination age could be higher or lower.

Policy and Certificate – Premiums

1) Premiums may be paid by the insured from day one or after 30, 60, or 90 days. If after 30, 60, or 90 days then premium will be paid by policyholder or participating organization for these days.
2) Premiums payment may be paid monthly, quarterly, semi-annually, or annually. Premium mode may or may not be changed.
3) Reinstatement of Insurance provision may or may not be included.

Policy and Certificate – General Provisions

1) Other Insurance In This Company provision may or may not be included.
2) Certificates may be returned in 30, 60, or 90 days depending on the account.

Riders

Accident Hospital Indemnity Benefit

1) First sentence will include either Policy or Certificate depending on the form to which it is being attached.
2) Successive periods of Confinement language may or may not be included.
3) Additional exclusions may or may not be included or just some may be included.
4) Last sentence will include either Policy or Certificate depending on the form to which it is being attached.

Accidental Death Benefit Rider

1) First sentence will include either Policy or Certificate depending on the form to which it is being attached.
2) Last sentence will include either Policy or Certificate depending on the form to which it is being attached.

Seat Belt Benefit Rider

1) First sentence will include either Policy or Certificate depending on the form to which it is being attached.
2) Last sentence will include either Policy or Certificate depending on the form to which it is being attached.

Mobility Benefit Rider

1) First sentence will include either Policy or Certificate depending on the form to which it is being attached.
2) Last sentence will include either Policy or Certificate depending on the form to which it is being attached.

Child Survivor Benefit Rider

1) First sentence will include either Policy or Certificate depending on the form to which it is being attached.
2) Last sentence will include either Policy or Certificate depending on the form to which it is being attached.

Physician Office Visit & Wellness Benefit Rider

1) Title - Wellness Benefit may or may not be included.
2) First paragraph Wellness Benefit may or may not be included. Policy or Certificate will be included depending on the form to which the rider is being attached.
3) Second paragraph may or may not be included.
4) Third paragraph Sickness may or may not be included.
5) Treatment of injury must occur within 30-90 days of the accident causing the injury may or may not be included. If included, days could be 30 to 90.
6) Definitions of Sickness and Wellness may or may not be included depending on whether or not Wellness is included.
7) Last sentence will include either Policy or Certificate depending on the form to which it is being attached.

Emergency Room Visit Benefit Rider

1) First sentence will include either Policy or Certificate depending on the form to which it is being attached.
2) Additional Exclusions will either be all included, all excluded, or only some included.
3) Last sentence will include either Policy or Certificate depending on the form to which it is being attached.

Life, Accident & Health, Annuity, Credit Transmittal Document

1.	**Prepared for the State of**	Arkansas

2.	**Department Use Only**
	State Tracking ID

3.	**Insurer Name & Address**	**Domicile**	**Insurer License Type**	**NAIC Group #**	**NAIC #**	**FEIN #**	**State #**
Transamerica Life Insurance Company 4333 Edgewood Road, N.E. Cedar Rapids IA 52499		IA		468	86231	39-0989781	

4.	**Contact Name & Address**	**Telephone #**	**Fax #**	**E-mail Address**
Mary J. DiMarcantonio, ALHC 520 Park Avenue Baltimore MD 21201		800-233-4624	410-209-5910	mdimarcantonio@aegonusa.com

5.	**Requested Filing Mode**	☒ Review & Approval ☐ File & Use ☐ Informational ☐ Combination (please explain): _____ ☐ Other (please explain): _____

6.	**Company Tracking Number**	HA AR0044307F01	
7.	☐ **New Submission** ☐ **Resubmission**	Previous file # _____	
8.	**Market**	☐ Individual ☐ Franchise	
		Group	☐ Small ☐ Large ☒ Small and Large ☐ Employer ☐ Association ☐ Blanket ☒ Discretionary ☒ Trust ☐ Other: _____
9.	**Type of Insurance**	H02G Group Health - Accident Only	
10.	**Product Coding Matrix Filing Code**	H02G.000 Health - Accident Only	
11.	**Submitted Documents**	☐ **FORMS** ☐ Policy ☐ Outline of Coverage ☐ Certificate ☐ Application/Enrollment ☐ Rider/Endorsement ☐ Advertising ☐ Schedule of Benefits ☐ Other: _____ ☐ **RATES** ☐ New Rate ☐ Revised Rate ☐ **FILING OTHER THAN FORM OR RATE:** Please explain: _____ **SUPPORTING DOCUMENTATION** ☐ Articles of Incorporation ☐ Third Party Authorization ☐ Association Bylaws ☐ Trust Agreement ☐ Statement of Variability ☐ Certifications ☐ Actuarial Memorandum ☐ Other: _____	

12.	**Filing Submission Date**	
13.	**Filing Fee (If required)**	Amount _____ Check Date _____ Retaliatory ☐ Yes ☐ No Check Number _____
14.	**Date of Domiciliary Approval**	
15.	**Filing Description:**	

The attached forms are being filed for your review and approval. These forms are new and do not replace any existing forms.

This product is a group policy that pays either a lump sum benefit upon an accidental loss (as defined in the policy) or provides an extended pay out option of the benefit. The covered person will elect how they want the benefits paid.

Additionally, there are optional rider benefits available with this plan. These optional benefits are, Accident Hospital Indemnity Benefit Rider, Accidental Death Benefit Rider, Seat Belt Benefit Rider, Mobility Benefit Rider, Child Survivor Benefit Rider, Physician Office Visit & Wellness Benefit Rider, and an Emergency Room Visit Benefit Rider.

This product will be marketed to Financial Institutions, mortgage customers, and credit card customers on a direct mail basis.

If you should have any questions concerning this filing, please contact me.

16. Certification (If required)

I HEREBY CERTIFY that I have reviewed the applicable filing requirements for this filing, and the filing complies with all applicable statutory and regulatory provisions for the state of Arkansas.

Print Name Mary J. DiMarcantonio, ALHC Title Filing Specialist

Signature Mary J. DiMarcantonio Date _____

17.	Form Filing Attachment
This filing transmittal is part of company tracking number	HA AR0044307F01
This filing corresponds to rate filing company tracking number	

	Document Name Description	Form Number		Replaced Form Number Previous State Filing Number
01	CATASTROPHIC ACCIDENT INSURANCE POLICY	TCA1000GP	☒ Initial ☐ Revised ☐ Other _____	
02	GROUP CATASTROPHIC ACCIDENT INSURANCE CERTIFICATE	TCA1000GC	☒ Initial ☐ Revised ☐ Other _____	
03	GROUP NON-CONTRIBUTORY CATASTROPHIC ACCIDENT INSURANCE CERTIFICATE	TCA2000GC	☒ Initial ☐ Revised ☐ Other _____	
04	ACCIDENT HOSPITAL INDEMNITY BENEFIT RIDER	TCA1001GR	☒ Initial ☐ Revised ☐ Other _____	
05	ACCIDENTAL DEATH BENEFIT RIDER	TCA1002GR	☒ Initial ☐ Revised ☐ Other _____	
06	SEAT BELT BENEFIT RIDER	TCA1003GR	☒ Initial ☐ Revised ☐ Other _____	
07	MOBILITY BENEFIT RIDER	TCA1004GR	☒ Initial ☐ Revised ☐ Other _____	
08	CHILD SURVIVOR BENEFIT RIDER	TCA1005GR	☒ Initial ☐ Revised ☐ Other _____	
09	PHYSICIAN OFFICE VISIT & WELLNESS BENEFIT RIDER	TCA1006RM	☒ Initial ☐ Revised ☐ Other _____	
10	EMERGENCY ROOM VISIT BENEFIT RIDER	TCA1007RM	☒ Initial ☐ Revised ☐ Other _____	
11	ENROLLMENT FORM	TCA1100GE	☒ Initial ☐ Revised ☐ Other _____	

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5.	**Requested Filing Mode**	☒ Review & Approval ☐ File & Use ☐ Informational ☐ Combination (please explain): _____ ☐ Other (please explain): _____

6.	**Company Tracking Number**	HA AR0044307F01	
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8.	**Market**	☐ Individual ☐ Franchise	
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9.	**Type of Insurance**	H02G Group Health - Accident Only	
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11.	**Submitted Documents**	☐ **FORMS** ☐ Policy ☐ Outline of Coverage ☐ Certificate ☐ Application/Enrollment ☐ Rider/Endorsement ☐ Advertising ☐ Schedule of Benefits ☐ Other: _____ ☐ **RATES** ☐ New Rate ☐ Revised Rate ☐ **FILING OTHER THAN FORM OR RATE:** Please explain: _____ **SUPPORTING DOCUMENTATION** ☐ Articles of Incorporation ☐ Third Party Authorization ☐ Association Bylaws ☐ Trust Agreement ☐ Statement of Variability ☐ Certifications ☐ Actuarial Memorandum ☐ Other: _____	

12.	**Filing Submission Date**	
13.	**Filing Fee (If required)**	Amount _____ Check Date _____ Retaliatory ☐ Yes ☐ No Check Number _____
14.	**Date of Domiciliary Approval**	
15.	**Filing Description:**	

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This product will be marketed to Financial Institutions, mortgage customers, and credit card customers on a direct mail basis, by inbound and outbound telemarketing, and on the internet.

If you should have any questions concerning this filing, please contact me.

16. Certification (If required)

I HEREBY CERTIFY that I have reviewed the applicable filing requirements for this filing, and the filing complies with all applicable statutory and regulatory provisions for the state of Arkansas.

Print Name Mary J. DiMarcantonio, ALHC Title Filing Specialist

Signature Mary J. DiMarcantonio Date 10/21/08